

**DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HEALTH AND RECOVERY SERVICES ADMINISTRATION
Olympia, Washington**

To: Dental Providers
Managed Care Organizations

Memorandum No: 06-40
Issued: June 28, 2006

From: Douglas Porter, Assistant
Secretary
Health and Recovery Services
Administration (HRSA)

For information contact
800.562.3022 or go to:
<http://maa.dshs.wa.gov/contact/prucontact.asp>

Supersedes # Memorandum: 05-40

Subject: Dental Program: Fee Schedule Changes

Effective for dates of service on and after July 1, 2006, the Health and Recovery Services Administration (HRSA) will implement:

- The updated Medicare Physician Fee Schedule Data Base (MPFSDB) Year 2006 relative value units (RVUs); and
- A one percent (1%) vendor rate increase for dental services for clients age 0-20.

Maximum Allowable Fees

HRSA is updating the Dental Program fee schedule with Year 2006 RVUs as appropriate. The 2006 Washington State Legislature **appropriated a vendor rate increase of one percent (1%)** for the 2007 state fiscal year which will be applied only to dental services for clients age 0-20. The maximum allowable fees have been adjusted to reflect these changes.

Visit HRSA's web site at <http://maa.dshs.wa.gov>. To view a current fee schedule, click ***Provider Publications/Fee Schedules***, then ***Accept***, then ***Fee Schedules***.

Bill HRSA your usual and customary charge.

Visit the Dental Program web site at: <http://maa.dshs.wa.gov/ProvRel/Dental/Dental.html>.

National Correct Coding Initiative

HRSA continues to implement the National Correct Coding Initiative (NCCI) policy. The Centers for Medicare and Medicaid Services (CMS) created this policy to promote national correct coding methods. NCCI assists HRSA to control improper coding that may lead to inappropriate payment. HRSA bases coding policies on:

- The American Medical Association's (AMA) Current Procedural Terminology (CPT®) manual;
- National and local policies and edits;
- Coding guidelines developed by national professional societies;
- The analysis and review of standard medical and surgical practices; and
- Review of current coding practices.

HRSA may perform a post-pay review on any claim to ensure compliance with NCCI. Visit the NCCI on the web at <http://www.cms.hhs.gov/physicians/cciedits>.

Place of Service

Reminder: Effective July 1, 2006, all claims submitted to HRSA must include the appropriate Medicare **two-digit place of service code**. Claims with a single-digit place of service code will be denied.

Billing Instructions Replacement Pages

Attached are updated replacement pages D.17-D.48, E.17-E.40, and a new Appendix. The new fees are located in the Appendix.

How do I conduct business electronically with HRSA?

You may conduct business electronically with HRSA by accessing the WAMedWeb at <http://wamedweb.acs-inc.com>.

How can I get HRSA's provider documents?

To obtain DSHS/HRSA provider numbered memoranda and billing instruction, go to the DSHS/HRSA website at <http://hrsa.dshs.wa.gov> (click *the Billing Instructions and Numbered Memorandum* link). These may be downloaded and printed.

Diagnostic

Clinical Oral Evaluations

HRSA does not pay separately for chart or record set-up. The fees for these services are included in HRSA's reimbursement for Comprehensive Oral Evaluations (D0150) and Limited Oral Evaluations (D0140).				
Procedure Code	Description/Limitations	EPA Number	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D0120	Periodic oral evaluation A periodic evaluation is allowed once every six months. A comprehensive examination must precede a periodic oral evaluation by at least six months.	No	See Appendix	See Appendix
D0140	Limited oral evaluation An evaluation limited to a specific oral health problem. A limited examination may also be billed when providing an evaluation for a referral. May not be billed when any prescheduled dental service is provided on the same date- except for palliative treatment and radiographs, necessary to diagnose the emergency condition.	No	See Appendix	See Appendix
D0150	Comprehensive oral evaluation An initial evaluation allowed once per client, per provider, per clinic and must include: <ul style="list-style-type: none"> i. A complete dental and medical history and a general health assessment; ii. A complete thorough evaluation of extra-oral and intra-oral hard and soft tissue; and iii. The evaluation and recording of dental caries, missing or erupted teeth, restoration, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, and oral cancer screening. 	No	See Appendix	See Appendix

Limited Visual Oral Assessment

This procedure code requires expedited prior authorization. (See page D14 for information on the Expedited Prior Authorization process.)				
A limited visual oral health assessment does not replace an oral evaluation by a dentist.				
Procedure Code	Description/Limitations	EPA Number	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D9999	Limited visual oral assessment EPA Criteria When billing for this code (D9999) and placing the assigned EPA number 870000998 onto the ADA claim form, a dental provider is verifying that one of the following occurred: <ul style="list-style-type: none"> • An assessment was made to determine the need for sealants to be placed by a dental hygienist; • Triage services were provided; • A public health dental hygienist performed an intraoral screening of soft tissues to assess the need for prophylaxis, sealants, fluoride varnish, or referral for other dental treatments by a dentist; or • In circumstances where the client will be referred to a dentist for treatment, the referring provider will not provide treatment or provide a full evaluation at the time of the assessment. This procedure also includes appropriate referrals, charting, patient data and oral health status, and informing the parent or guardian of the results. Refer to page D.15 for information on Expedited Prior Authorization.	Yes 870000998	See Appendix	See Appendix

Radiographs

Doing both a panoramic film and an intraoral complete series is not allowed.				
Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D0210	Intraoral – complete series (including bitewings) A complete intraoral series consists of 14 periapicals and one series of 4 bitewings. Complete series radiographs will be allowed only once in a 3-year period.	No	See Appendix	See Appendix
D0220	Intraoral periapical – single, first film	No	See Appendix	See Appendix
D0230	Intraoral periapical – each additional film	No	See Appendix	See Appendix
D0240	Intraoral – occlusal, film	No	See Appendix	See Appendix
When billing D0270 and D0272 on the same date of service, HRSA's total reimbursement amount will not exceed the reimbursement for D0274.				
D0270	Bitewing – single film Total of 4 bitewings allowed every 12 months.	No	See Appendix	See Appendix
D0272	Bitewings – 2 films Total of 4 bitewings allowed every 12 months	No	See Appendix	See Appendix
D0274	Bitewings – 4 films Total of 4 bitewings allowed every 12 months.	No	See Appendix	See Appendix
D0321	Temporomandibular joint film	No	See Appendix	See Appendix
D0330	Panoramic film – maxilla and mandible Allowable for oral surgical purposes only. Not to be used for restoration diagnostic purposes. Documentation must be entered in the client's file. Panoramic-type films are allowed once in a 3-year period. A shorter interval between panoramic radiographs may be allowed for: <ul style="list-style-type: none"> Emergent services, with authorization from HRSA within 72 hours of the service; Continued next page.	No	See Appendix	See Appendix

Dental Program - Children

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
	<ul style="list-style-type: none"> • Oral surgical with written prior authorization from HRSA; • Orthodontic services (see HRSA's <i>Orthodontic Services Billing Instructions</i>); or • Preoperative or postoperative surgery cases. Preoperative radiographs must be provided within 14 days prior to surgery, and postoperative radiographs must be provided within 30 days after surgery. 			

Test and Laboratory Examination

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D0460	Pulp vitality test <ul style="list-style-type: none"> • Allowed one time per day (not per tooth); • For diagnosis of emergency conditions only; and • Not allowed when performed on the same date as any other procedure, with the exception of an emergency examination or palliative treatment. 	No	See Appendix	See Appendix
D0501	Histopathologic examination Histological examination of oral hard/soft tissue.	No	See Appendix	See Appendix

Preventive

Prophylaxis (Scaling and coronal polishing)

<ul style="list-style-type: none"> No additional allowance will be given for a cavitron or ultrasonic scaling. Prophylaxis and topical application of fluoride must be billed separately. Not allowed when performed on the same date of service as periodontal scaling or gingivectomy. 				
Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D1110	Prophylaxis - adult [age 19-20] Allowed once every 12 months. Prophylaxis for DD clients allowed three times in 12 months.	No	See Appendix	See Appendix
D1120	Prophylaxis – child [age 8-18] Allowed once every six months. Prophylaxis for DD clients allowed three times in 12 months.	No	See Appendix	See Appendix
D1330	Oral hygiene instructions [child age 0-7] Allowed once every six months. Includes prophylaxis.	No	See Appendix	See Appendix

Fluoride Treatments

<ul style="list-style-type: none"> Fluoride treatments are not covered as a routine adult service for persons 19-20 years of age. This service requires prior authorization for this age group, unless provided to a DDD client. Document in the client's file which material (e.g., topical gel or fluoride varnish) is used. 				
Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D1203	Topical application of fluoride [gel or varnish] (prophylaxis not included) – child [age 0-18] Allowed up to three times in a 12-month period. Additional applications may be reimbursed with prior authorization .	No	See Appendix	See Appendix
D1204	Topical application of fluoride (prophylaxis not included) – adult [age 19-20 for xerostomia only]. Allowed up to three times in a 12-month period.	Yes	See Appendix	See Appendix

Other Preventive Services

<ul style="list-style-type: none"> Sealants may be applied to occlusal surfaces of primary and permanent maxillary and mandibular first and second molars and lingual pits of teeth 7 and 10. Only teeth with no decay will be covered. Sealants are restricted to children 0 through 18 years of age. The application of pit and fissure sealants will be covered only once per tooth in a 3-year period. 				
Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D1351	Topical application of sealants – per tooth Tooth and surface designations required. Includes glass ionomer sealants.	No	See Appendix	See Appendix

Space Maintenance

Space maintainers will be allowed as follows: <ul style="list-style-type: none"> To hold space for missing first and/or second primary molars. Space maintainers are allowed for maintaining positioning for permanent teeth for spaces A, B, I, J, K, L, S and T for clients 18 years of age and younger. No additional allowance will be given on a lingual arch space maintainer for 3 teeth. No reimbursement will be allowed for removing retainers. Vertical space maintainers are not covered. 				
Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D1510	Space maintainer - fixed – unilateral Allowed only once per quadrant. Quadrant designation required.	No	See Appendix	See Appendix
D1515	Space maintainer – fixed – bilateral Allowed only once per arch. Arch designation required.	No	See Appendix	See Appendix
D1550	Recementation of space maintainer Allowed once per quadrant or arch. Quadrant or arch designation required.	No	See Appendix	See Appendix

Restorative

Amalgam Restorations (including polishing)

<ul style="list-style-type: none"> Multiple restorations involving the same surface of the same tooth are considered as a single surface and are reimbursed as such. Multiple restorations involving the proximal and occlusal surfaces of the same tooth are considered to be a multisurface restoration and are reimbursed as such. Reimbursement for all pit restorations is allowed as though for one surface amalgam. Bases and polishing amalgams are included in the allowance for the major restoration. Amalgams and resin-based composite restorations are covered only once in a 2-year period. This applies only to the same surface of the same tooth. If this surface is redone with an additional adjoining surface, all restored surfaces will be covered. Replacement within a 2-year period requires written justification on claim form and in patient record. Amalgam and/or resin build-ups are included in reimbursement for crowns. HRSA does not cover flowable composites as a restoration. 				
Procedure Code	Description/Limitation	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D2140	Amalgam – 1 surface, primary or permanent Tooth and surface designations required.	No	See Appendix	See Appendix
D2150	Amalgam – 2 surfaces, primary or permanent Tooth and surface designations required.	No	See Appendix	See Appendix
D2160	Amalgam – 3 surfaces, primary or permanent Tooth and surface designations required.	No	See Appendix	See Appendix
D2161	Amalgam – 4 or more surfaces, primary or permanent Tooth and surface designations required.	No	See Appendix	See Appendix

Resin-Based Composite Restorations (Composite/Glass Ionomer)

Proximal restorations that do not involve the incisal angle in the anterior tooth are considered to be a one or two-surface restoration.				
Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D2330	Resin-based composite – 1 surface, anterior Tooth and surface designations required.	No	See Appendix	See Appendix
D2331	Resin-based composite – 2 surfaces, anterior Tooth and surface designations required.	No	See Appendix	See Appendix
D2332	Resin-based composite – 3 surfaces, anterior Tooth and surface designations required.	No	See Appendix	See Appendix
D2335	Resin-based composite – 4 or more surfaces or involving incisal angle (anterior) Tooth and surface designations required.	No	See Appendix	See Appendix
D2390	Resin-based composite crown, anterior Tooth designation required.	No	See Appendix	See Appendix
D2391	Resin-based composite – 1 surface, posterior Tooth and surface designations required.	No	See Appendix	See Appendix
D2392	Resin-based composite – 2 surface, posterior Tooth and surface designations required.	No	See Appendix	See Appendix
D2393	Resin-based composite – 3 surfaces, posterior Tooth and surface designations required.	No	See Appendix	See Appendix
D2394	Resin-based composite, 4 or more surfaces, posterior Tooth and surface designations required.	No	See Appendix	See Appendix

Crowns for Children

Use the final seating date, not the preparation date, as the date of service.

Crowns not requiring prior authorization

[WAC 388-535-1230(1)]

- The Health and Recovery Administration (HRSA) covers the following crowns for children **without prior authorization**:
 - ✓ Stainless steel. HRSA considers these as permanent crowns, and does not cover them as temporary crowns; and
 - ✓ Nonlaboratory resin for primary anterior teeth.

Crowns that require prior authorization

Laboratory Processed Crowns

[WAC 388-535-1230(2)(3)]

- HRSA requires prior authorization for the following crowns, which are limited to **single** restorations for permanent anterior maxillary and mandibular teeth 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, and 27:
 - ✓ Resin (laboratory);
 - ✓ Porcelain with ceramic substrate;
 - ✓ Porcelain fused to high noble metal;
 - ✓ Porcelain fused to predominantly base metal; and
 - ✓ Porcelain fused to noble metal.
- HRSA does not cover laboratory-processed crowns for posterior teeth.

Radiographs are required by HRSA for confirmation that the requested service meets criteria.

Criteria for crowns

[WAC 388-535-1230(4)(5)]

- Criteria for covered crowns as described on the previous page is:
 - ✓ Crowns may be authorized when the crown is medically necessary.
 - ✓ Coverage is based upon a supportable five-year prognosis that the client will retain the tooth if the tooth is crowned. The provider must submit the following client information:
 - The overall condition of the mouth;
 - Oral health status;
 - Client maintenance of good oral health status;
 - Arch integrity; and
 - Prognosis of remaining teeth (prognosis of remaining teeth must not be more involved than periodontal case type II).
 - ✓ Anterior teeth must show traumatic or pathological destruction to loss of at least one incisal angle.
- The laboratory-processed crowns described on the previous page are covered:
 - ✓ Only when a lesser service will not suffice because of extensive coronal destruction, and treatment is beyond intracoronal restoration;
 - ✓ Only once per permanent tooth in a five-year period;
 - ✓ For endodontically treated anterior teeth only after satisfactory completion of the root canal therapy. Post-endodontic treatment radiographs must be submitted for prior authorization of these crowns.

Note: Endodontic treatment alone is not justification for authorization of a crown.
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Reimbursement for crowns

[WAC 388-535-1230(6)]

HRSA reimburses only for the covered crowns listed in this section. The reimbursement is full payment. All of the following are included in the reimbursement and must not be billed separately:

- Tooth and soft tissue preparations;
- Amalgam or resin build-ups;
- Temporary crowns;
- Cement bases;
- Insulating bases;
- Impressions;
- Seating; and
- Local anesthesia.

Temporary crowns are included in HRSA's total reimbursement for crowns. HRSA does not reimburse separately for temporary crowns.

Prior authorization is required for all but one of the following crowns. Payment will be denied for claims not having prior authorization. Temporary crowns are included in HRSA's total reimbursement for crowns. HRSA does not reimburse separately for temporary crowns.

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D2390	Resin-based composite crown, anterior Tooth designation required.	No	See Appendix	See Appendix
D2710	Crown – resin (laboratory) Tooth designation required. Covered for upper & lower permanent anterior teeth only.	Yes	See Appendix	See Appendix
D2740	Crown – porcelain/ceramic substrate Tooth designation required. Covered for upper & lower permanent anterior teeth only.	Yes	See Appendix	See Appendix
D2750	Crown – porcelain fused to high noble metal Tooth designation required. Covered for upper & lower permanent anterior teeth only.	Yes	See Appendix	See Appendix
D2751	Crown – porcelain fused to predominantly base metal Tooth designation required. Covered for upper & lower permanent anterior teeth only.	Yes	See Appendix	See Appendix
D2752	Crown – porcelain fused to noble metal Tooth designation required. Covered for upper & lower permanent anterior teeth only.	Yes	See Appendix	See Appendix

Other Restorative Services

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D2910	Recement inlay Tooth designation required.	No	See Appendix	See Appendix
D2920	Recement crown Tooth designation required.	No	See Appendix	See Appendix
D2930	Prefabricated stainless steel crown – primary tooth Tooth designation required.	No	See Appendix	See Appendix
D2931	Prefabricated stainless steel crown – permanent tooth Tooth designation required.	No	See Appendix	See Appendix
D2933	Prefabricated stainless steel crown with resin window Covered for upper anterior primary teeth C through H only. Tooth designation required.	No	See Appendix	See Appendix
D2950	Core buildup (including pins) Tooth designation required.	Yes	See Appendix	See Appendix

Endodontic

Pulpotomy (excluding final restoration)

D3220	Therapeutic pulpotomy Covered only as complete procedure, once per tooth. For primary teeth only. Tooth designation required.	No	See Appendix	See Appendix
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Root Canal Therapy

<ul style="list-style-type: none"> Includes clinical procedures and follow-up care. Separate charges are allowable for open and drain and for root canal treatments if the procedures are done on different days. Not covered for primary teeth. 				
Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D3310	Anterior (excluding final restoration) Tooth designation required.	No	See Appendix	See Appendix
D3320	Bicuspid (excluding final restoration) Tooth designation required.	No	See Appendix	See Appendix
D3330	Molar (excludes final restoration) Tooth designation required. Not covered for wisdom teeth.	No	See Appendix	See Appendix

Endodontic Retreatment

These three codes are not payable to the provider who did the initial root canal. The provider performing the service(s) must submit pre-treatment and post-treatment radiographs to HRSA.				
Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D3346	Retreatment of previous root canal therapy – anterior	Yes	See Appendix	See Appendix
D3347	Retreatment of previous root canal therapy – bicuspid	Yes	See Appendix	See Appendix
D3348	Retreatment of previous root canal therapy – molar Not covered for wisdom teeth	Yes	See Appendix	See Appendix

Apexification/Recalcification Procedures

Not covered on primary teeth.				
Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc) Tooth designation required.	No	See Appendix	See Appendix
D3352	Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.) HRSA pays up to 5 medically necessary visits. Tooth designation required.	No	See Appendix	See Appendix

Apexification/Periradicular Services

Not covered on primary teeth				
Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D3410	Apicoectomy/periradicular surgery – anterior Tooth designation required.	No	See Appendix	See Appendix
D3421	Apicoectomy/periradicular surgery – bicuspid (first root) Tooth designation required.	No	See Appendix	See Appendix
D3425	Apicoectomy/periradicular surgery – molar (first root) Tooth designation required.	No	See Appendix	See Appendix
D3426	Apicoectomy/periradicular surgery (each additional root) Tooth designation required.	No	See Appendix	See Appendix
D3430	Retrograde filling, per root Only covered if done with apicoectomy. Tooth designation required.	No	See Appendix	See Appendix

Other Endodontic Procedures

Anterior primary teeth are not covered				
Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D3950	Canal preparation and fitting of preformed dowel or post. HRSA covers only the dowel or post portion of this procedure. Payable only once per tooth and may include multiple dowels or posts. Tooth designation required.	No	See Appendix	See Appendix

Periodontics

Surgical Services

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant Quadrant designation required.	No	See Appendix	See Appendix

Non-Surgical Periodontal Service

For CDT code D4341:

- Allowed for clients age 19-20 and DDD clients (see page D.5).
- **Not covered for clients age 0-18.**
- Allowed only when the client has radiographic evidence of periodontal disease.
- There must be supporting documentation in the client's record, including complete periodontal charting and a definitive periodontal diagnosis.
- Allowed only when the client's clinical condition meets existing periodontal guidelines.
- Allowed once per quadrant in 24-month period, quadrant designation is required.
- Not allowed when performed on the same date of service as oral prophylaxis, periodontal maintenance, gingivectomy or gingivoplasty.
- Ultrasonic scaling, gross scaling, or gross debridement procedures may be included in the procedure, but are not substitutes for, periodontic scaling and root planing.

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D4341	Periodontal scaling and root planing, four or more contiguous teeth or bounded teeth spaces, per quadrant	No	See Appendix	See Appendix
D4342	Periodontal scaling and root planing (1-3 teeth, per quadrant)	No	See Appendix	See Appendix

Periodontal Maintenance

<ul style="list-style-type: none"> • Allowed for DDD clients three times per year; • Allowed for clients age 19 through 20 every 12 months; • Allowed only when the client has been previously treated for periodontal disease, including surgical or nonsurgical periodontal therapy; • Allowed when supporting documentation in the client's record includes a definitive periodontal diagnosis and complete periodontal charting; • Allowed when the client's clinical condition meets existing periodontal guidelines; • Allowed when periodontal maintenance starts at least 12 months after completion of periodontal scaling and root planing or surgical treatment and paid only at 12-month intervals. • Not reimbursed when the periodontal maintenance is performed on the same date of service as oral prophylaxis or periodontal scaling and root planing, gingivectomy, or gingivoplasty. • Reimbursed only if oral prophylaxis is not billed for the same client within the same 12-month period. 				
Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D4910	Periodontal Maintenance [full mouth – not per quadrant]	No	See Appendix	See Appendix

Dentures & Partial Dentures for Children

Use the seating date to bill for dentures.

Initial Set of Dentures

[Refer to WAC 388-535-1080(1)(2)]

- The Health and Recovery Administration (HRSA) covers for children only one maxillary denture and one mandibular denture per client in a ten-year period, **and considers that set to be the first set.**
- **HRSA does not require prior authorization for the first set of dentures.** (See exception for laboratory and professional fees for dentures and partials, page D.36.)
- The first set of dentures may be any of the following:
 - ✓ An immediate set (constructed prior to removal of the teeth);
 - ✓ An initial set (constructed after the client has been without teeth for a period of time); or
 - ✓ A final set (constructed after the client has received immediate or initial dentures).
- The first maxillary denture and the first mandibular denture must be of the structure and quality to be considered the primary set. HRSA does not cover transitional or treatment dentures.

Partials [Refer to WAC 388-535-1080(3)]

- HRSA covers partials (resin and cast base) once every five years subject to the following limits:
 - ✓ Cast base partials only when replacing three or more teeth per arch excluding wisdom teeth; and
 - ✓ No partials are covered when they replace wisdom teeth only.

Exception: The exception to this is replacement dentures, which may be allowed as specified under *Replacement of Complete or Partial Dentures*.

Replacement of Complete or Partial Dentures

[Refer to WAC 388-535-1080(4)]

HRSA requires prior authorization for replacement dentures or partials requested within one year of the seat date.

- HRSA does not require prior authorization for replacement dentures or partials when:
 - ✓ The client's existing dentures or partials meet **one of the following conditions**:
 - No longer serviceable and cannot be relined or rebased; or
 - Damaged beyond repair; and
 - ✓ The client's health would be adversely affected by absence of dentures; and
 - ✓ The client has been able to wear dentures successfully; and
 - ✓ The need for dentures or partials meet the criteria of medically necessary.
- Dentures replacing a lost maxillary denture and/or a mandibular denture must not exceed HRSA's limit of one set in a ten-year period.

For partial dentures:

- ✓ Chart the **missing teeth** on the claim form **and** in the client's record; **and**
- ✓ In the "Remarks" field on the ADA claim form, write the justification for replacement of complete or partial dentures; or
- ✓ If billing electronically, enter the justification in the "Comments/Remarks" field.

For complete dentures:

- ✓ In the "Remarks" field on the ADA claim form, write the justification for replacement of complete or partial dentures; or
- ✓ If billing electronically, enter the justification in the "Comments/Remarks" field.

Laboratory and Professional Fees for Dentures and Partial

[Refer to WAC 388-535-1080(5)]

- HRSA does not reimburse separately for laboratory and professional fees for dentures and partials. However, HRSA may partially reimburse for these fees when the provider obtains prior authorization and the client:
 - ✓ Dies;
 - ✓ Moves from the state;
 - ✓ Cannot be located; or
 - ✓ Does not participate in completing the dentures.

Rebase [Refer to WAC 388-535-1080(10)(11)]

HRSA covers one rebase in a five-year period; the dentures must be at least three years old.

Billing [Refer to WAC 388-535-1080(7)(8)(9)]

- For billing purposes, the provider may use the impression date as the service date for dentures, including partials, only when:
 - ✓ Related dental services including laboratory services were provided during a client's eligible period; and
 - ✓ The client is not eligible at the time of delivery.
- For billing purposes, the provider may use the delivery date as the service date when the client is using the first set of dentures in lieu of noncovered transitional or treatment dentures after oral surgery.
- HRSA includes the cost of relines and adjustments that are done within six months of the seat date in the reimbursement for the dentures.

The requirements in this section also apply to overdentures.

Dentures, partial dentures and rebased dentures require labeling in accordance with RCW 18.32.695.

Dental Program - Children

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs

Complete Dentures (including six months post-delivery care)

<ul style="list-style-type: none"> The HRSA dental program covers one set of dentures in a ten-year period. Dentures placed immediately must be of structure and quality to be considered the permanent set. Transitional dentures are not covered. No additional reimbursement is allowed for denture insertions. 				
D5110	Complete denture – maxillary (upper)	No	See Appendix	See Appendix
D5120	Complete lower – mandibular (lower)	No	See Appendix	See Appendix
D5130	Immediate denture – maxillary (upper) Appropriate radiographs must be submitted to HRSA.	No	See Appendix	See Appendix
D5140	Immediate denture – mandibular (lower) Appropriate radiographs must be submitted to HRSA.	No	See Appendix	See Appendix

Partial Dentures (including six months post-delivery care)

<ul style="list-style-type: none"> One partial per arch is covered. D5211 and D5212 are covered for one or more teeth, excluding wisdom teeth. D5213 and D5214 are covered only when replacing three or more teeth per arch, excluding wisdom teeth. HRSA pays for partials covered by HRSA once in five years. 				
D5211	Maxillary partial denture – resin base (includes any conventional clasps, rests and teeth)	No	See Appendix	See Appendix
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	No	See Appendix	See Appendix
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	No	See Appendix	See Appendix
D5214	Mandibular partial denture – cast metal framework with resin denture bases (includes any conventional clasps, rests and teeth)	No	See Appendix	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs

Lab and Professional Fees for Complete/Partial Dentures

D5899	Unspecified removable prosthodontic procedure Laboratory and professional fees may be paid for complete dentures or partial dentures if the client: <ul style="list-style-type: none"> • Dies; • Moves from the state; • Cannot be located; or • Does not participate in completing the dentures. Requires prior authorization from HRSA. When requesting prior authorization, you must attach an invoice listing laboratory prescriptions and fees.	Yes	See Appendix	See Appendix
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Adjustments to Dentures and Partial

<ul style="list-style-type: none"> • No allowance for adjustments for 6 months following placement. • Adjustments done during this period are included in denture/partial allowance. 				
D5410	Adjust complete denture – maxillary (upper)	No	See Appendix	See Appendix
D5411	Adjust complete denture – mandibular (lower)	No	See Appendix	See Appendix
D5421	Adjust partial denture – maxillary (upper)	No	See Appendix	See Appendix
D5422	Adjust partial denture – mandibular (lower)	No	See Appendix	See Appendix

Repairs to Complete Dentures

D5510	Repair broken complete denture base Arch designation required.	No	See Appendix	See Appendix
D5520	Replace missing or broken teeth – complete denture Use for initial tooth. Tooth designation required.	No	See Appendix	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs

Repairs to Partial Dentures

D5610	Repair resin denture base Arch designation required.	No	See Appendix	See Appendix
D5620	Repair cast framework Arch designation required	No	See Appendix	See Appendix
D5630	Repair or replace broken clasp Arch designation required.	No	See Appendix	See Appendix
D5640	Replace broken teeth – per tooth Use for initial tooth. Tooth designation required.	No	See Appendix	See Appendix
D5650	Add tooth to existing partial denture Tooth designation required.	No	See Appendix	See Appendix
D5660	Add clasp to existing partial denture Tooth designation required.	No	See Appendix	See Appendix

Denture Rebasing Procedures

D5710	Rebase complete maxillary denture Requires justification (e.g., lost vertical dimension, incorrect bite). Original dentures must be at least 3 years old. Rebasing allowed once in a 5-year period.	No	See Appendix	See Appendix
D5711	Rebase complete mandibular denture Requires justification (e.g., lost vertical dimension, incorrect bite). Original dentures must be at least 3 years old. Rebasing allowed once in a 5-year period.	No	See Appendix	See Appendix
D5720	Rebase maxillary partial denture Requires justification (e.g., lost vertical dimension, incorrect bite). Original dentures must be at least 3 years old. Rebasing allowed once in a 5-year period.	No	See Appendix	See Appendix
D5721	Rebase mandibular partial denture Requires justification (e.g., lost vertical dimension, incorrect bite). Original dentures must be at least 3 years old. Rebasing allowed once in a 5-year period.	No	See Appendix	See Appendix

Dental Program - Children

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs

Denture Relining

<ul style="list-style-type: none"> Relines are included in allowance for dentures if service is provided within first six months of placement of dentures. Reline of partial or full dentures is not allowed more than once in a 5-year period. 				
D5750	Reline complete maxillary denture (laboratory)	No	See Appendix	See Appendix
D5751	Reline complete mandibular denture (laboratory)	No	See Appendix	See Appendix
D5760	Reline maxillary partial denture (laboratory)	No	See Appendix	See Appendix
D5761	Reline mandibular partial denture (laboratory)	No	See Appendix	See Appendix

Other Removable Prosthetic Services

D5850	Tissue conditioning, maxillary Included in allowance for dentures if service is provided within first six months of placement of dentures.	No	See Appendix	See Appendix
D5851	Tissue conditioning, mandibular Included in allowance for dentures if service is provided within first six months of placement of dentures.	No	See Appendix	See Appendix
D5860	Overdenture – Complete Arch designation required.	No	See Appendix	See Appendix
D5932	Obturator prosthesis, definitive	No	See Appendix	See Appendix
D5933	Obturator prosthesis, modification	No	See Appendix	See Appendix
D5952	Speech aid prosthesis, pediatric Covered for clients age 19 and 20 for cleft palate.	No	See Appendix	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs

Prosthodontics, Fixed Repairs

Prosthodontics, Fixed Repairs

D6930	Recent fixed partial denture (bridge)	No	See Appendix	See Appendix
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Management of Temporomandibular Joint Dysfunction

D7880	Occlusal orthotic device [Allowed for TMJ/TMD or bruxism only.] Laboratory-processed only. Requires prior authorization. Justification must include diagnosis. Laboratory invoice must be kept in the client's file. The maximum allowance includes all professional fees, lab costs, and all required follow-ups. One appliance allowed in a two-year period. Use the seat date to bill for occlusal orthotic device.	Yes	See Appendix	See Appendix
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Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs

Oral Surgery – Dentists

HRSA covers dental services that are medically necessary and provided in a non-office setting under the direction of a physician or dentist for:

- The care or treatment of teeth, jaws, or structures directly supporting the teeth, if the procedure requires hospitalization;
- Short stays or ambulatory surgery centers when the procedure cannot be done in an office setting (See “What dental-related services are not covered,” page D.10); and
- A hospital call, including emergency care, allowed one per day, per client, per provider.

Simple Extraction

(includes local anesthesia, suturing, if needed, and routine postoperative care)

D7111	Coronal remnants deciduous t	No	See Appendix	See Appendix
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No	See Appendix	See Appendix

Surgical Extractions

(includes local anesthesia, suturing, if needed, and routine postoperative care)

D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth Surgical removal of anterior teeth (7-10 and 23-26) requires prior authorization and must be justified with radiographs. Tooth designation required.	See Desc.	See Appendix	See Appendix
D7220	Removal of impacted tooth – soft tissue Tooth designation required.	No	See Appendix	See Appendix
D7230	Removal of impacted tooth – partially bony Tooth designation required.	No	See Appendix	See Appendix
D7240	Removal of impacted tooth – completely bony Allowed only when pathology is present. Tooth designation required.	No	See Appendix	See Appendix
D7241	Removal of impacted tooth - completely bony , with unusual surgical complications Allowed only when pathology is present. Tooth designation required.	No	See Appendix	See Appendix

Dental Program - Children

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs

Surgical Extractions (Continued)

D7250	Surgical removal of residual tooth roots (cutting procedure) Extraction must be performed by a different provider. Tooth designation required.	No	See Appendix	See Appendix
HRSA does not cover extraction of asymptomatic teeth. [WAC 388-535-1100(2)]				

Other Surgical Procedures

D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus Permanent teeth only. Tooth designation required.	No	See Appendix	See Appendix
D7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons. Includes orthodontic attachments. Tooth designation required; limited to clients age 20 and younger.	No	See Appendix	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs

Adjunctive General Services

Unclassified Treatment

D9110	Palliative (emergency) treatment of dental pain – minor procedure Emergency palliative treatment is: <ul style="list-style-type: none"> Allowed only when no other definitive treatment is performed on the same day; and Allowed once per client, per day. Separate charges are allowable for open and drain and for root canal treatment if the procedures are performed on different days. A description of the service must be documented in the client's file.	No	See Appendix	See Appendix
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Anesthesia

- HRSA covers general anesthesia, conscious sedation, and parenteral or multiple oral agents for medically necessary dental services as follows:
 - ✓ For treatment of clients of the Division of Developmental Disabilities;
 - ✓ For oral surgery procedures;
 - ✓ When justification for administering the general anesthesia instead of a lesser type of sedation is clearly documented in the client's record.
 - ✓ When the anesthesia is administered by:
 - An oral surgeon
 - An anesthesiologist;
 - A dental anesthesiologist;
 - A Certified Registered Nurse Anesthetist (CRNA), if the performing dentist has a current conscious sedation permit or a current general anesthesia permit from the Department of Health (DOH);
 - A dentist who has a conscious sedation permit (for conscious sedation with parenteral or multiple oral agents) issued by DOH that is current at the time the billed service(s) is provided; or
 - A dentist who has a general anesthesia permit (for deep sedation or general anesthesia) issued by DOH that is current at the time the billed service(s) is provided.
- When the provider meets the prevailing standard of care and at least the requirements in WAC 246-817-760, Conscious sedations with parenteral or multiple oral agents, and WAC 246-817-770, General anesthesia.
- When general anesthesia (including deep sedation) is administered by:
 - ✓ The attending dentist, HRSA reimburses at the rate of 50% of the maximum allowable rate.
 - ✓ A provider other than the attending dentist, HRSA reimburses at the maximum allowable rate.
- When billing for general anesthesia, show the beginning and ending times on the claim form. State the total number of minutes on the claim. Anesthesia time begins when the anesthesiologist or CRNA starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent) and ends when the anesthesiologist or CRNA is no longer in constant attendance (i.e., when the patient can be safely placed under post-operative supervision).
- The name of the provider who administered the anesthesia must be in the *Remarks* field (field 35) of the claim form, if that provider is different from the billing provider.

Dental Program - Children

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
<ul style="list-style-type: none">HRSA calculates payment according to the formula below for general anesthesia (to include deep sedation) administered by a dentist: \$102.20 + [TIME UNITS X \$20.44] = MAXIMUM ALLOWABLE FEE Note: Every 15 minute increment or fraction equals 1 time unit.Bill for pharmaceuticals using the appropriate code(s) below. If you are billing electronically, attach an itemized list of pharmaceuticals to the claim form. Send this information to HRSA as backup documentation for electronically billed claims for any charges exceeding \$45.00 (see <i>Important Contacts</i>).				
D9220	Deep sedation/general anesthesia When justification for administering the general anesthesia instead of a lesser type of sedation is clearly documented in the client’s record. HRSA’s reimbursement for D9220 includes the total time – not just the first 30 minutes as specified in the CDT book. See previous page for further information. (A General Anesthesia permit is required to be on file with HRSA from the provider/performing provider.)	No	See Appendix	See Appendix
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide HRSA does not cover analgesia or anxiolysis under the Dental Program. Use this code when billing for inhalation of nitrous oxide.	No	See Appendix	See Appendix
D9241	Intravenous conscious sedation/analgesia Conscious sedation with parenteral agents. (A Conscious Sedation permit is required to be on file with HRSA from the provider/performing provider.)	No	See Appendix	See Appendix
D9248	Non-intravenous conscious sedation Conscious sedation with multiple oral agents. (A Conscious Sedation permit is required to be on file with HRSA from the provider/performing provider.)	No	See Appendix	See Appendix

Dental Program - Children

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs

Professional Visits

<ul style="list-style-type: none"> Nursing facilities must provide dental-related necessary services per WAC 388-97-012. No additional payment will be made for multiple calls for patients in nursing facility settings. Procedures including evaluations or assessments must be billed with the appropriate procedure codes. A referral for dental care must be documented in the client's record. This referral may be initiated by the client, client's attending physician, facility nursing supervisor, or client's legal guardian when a dental problem is identified. The client or guardian has freedom of choice of dentist in the community. The on-staff dental provider may be called when the patient has no preference and concurs with the request. Medicaid-eligible clients in nursing facilities may not be billed for services that exceed those covered under this program. Services outside this program should be arranged by the nursing facility and may be covered under their rate structure. Mass screening for dental services of clients residing in a facility is not permitted. 				
D9410	House/extended care facility call Allowed once per day (not per client and not per facility), per provider.	No	See Appendix	See Appendix
D9420	Hospital calls (includes emergency care) Allowed once per day, per client, per provider. Not covered for routine preoperative and postoperative visits.	No	See Appendix	See Appendix

Dental Program - Children

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs

Drugs

D9610	Therapeutic drug injection. Antibiotics only. Includes cost of drug.	No	See Appendix	See Appendix
D9630	Other drugs and/or medicaments Use this code when billing for pharmaceuticals. Payable only when billed with either D9220, D9241, or D9248. HRSA limits this procedure code to parenteral and multiple oral agents for conscious sedation and general anesthesia agents only.	No	See Appendix	See Appendix

Miscellaneous Services

D9920	Behavior management Involves a client whose documented behavior requires the assistance of one additional dental professional staff to protect the patient from self-injury while treatment is rendered.	No	See Appendix	See Appendix
D9951	Occlusal adjustment, limited <ul style="list-style-type: none"> Allowed once every 12 months – per quadrant; Quadrant designation required; and Is included in the fee for restorations or crowns placed by the same provider. 	No	See Appendix	See Appendix

Dental Fee Schedule

Guide to using the fee schedule

Column 1:	Procedure Code (ADA CDT)
Column 2:	Description/Limitations
Column 3:	Prior Auth? Is prior authorization required?
Column 4:	Maximum Allowable – Adults age 21 and older.

Always bill your usual and customary fee(s) (not HRSA's maximum allowable amount).

Remember: You may bill only after services have been provided, but HRSA must receive your bill within 365 days from the date of service.

Unless otherwise specified, HRSA uses the descriptions of the ADA codes as listed in the CDT manual.

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up
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Diagnostic

Clinical Oral Evaluations

<p>HRSA does <u>not</u> pay separately for chart or record set-up. The fees for these services are included in HRSA's reimbursement for Comprehensive Oral Evaluations (D0150) and Limited Oral Evaluations (D0140).</p>			
D0120	<p>Periodic oral evaluation A periodic evaluation is allowed once every six months.</p> <p>A comprehensive examination must precede a periodic oral evaluation by at least six months.</p>	No	See Appendix
D0140	<p>Limited oral evaluation An evaluation limited to a specific oral health problem. A limited examination may also be billed when providing an evaluation for a referral.</p> <p>May not be billed when any prescheduled dental service is provided on the same date – except for palliative treatment and radiographs, necessary to diagnose the emergency condition.</p>	No	See Appendix
D0150	<p>Comprehensive oral evaluation</p> <p>An initial evaluation is allowed once per client, per provider or clinic, and must include:</p> <ul style="list-style-type: none"> i. A complete dental and medical history and a general health assessment; ii. A complete thorough evaluation of extra-oral and intra-oral hard and soft tissue; and iii. The evaluation and recording of dental caries, missing or erupted teeth, restoration, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, and oral cancer screening. 	No	See Appendix

Procedure Code	EPA Number	Description & Expedited Prior Authorization Criteria	Maximum Allowable 21 yrs & up
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Limited Visual Oral Assessment

THIS PROCEDURE CODE REQUIRES EXPEDITED PRIOR AUTHORIZATION.
See page E.16 for information on the Expedited Prior Authorization process.

A limited visual oral health assessment does not replace an oral evaluation by a dentist.

D9999	870000998	<p>Limited visual oral assessment</p> <p><u>EPA Criteria</u></p> <p>When billing for this code (D9999) and placing the assigned EPA number onto the ADA claim form, a dental provider is verifying that one of the following occurred:</p> <ul style="list-style-type: none"> • Triage services were provided; • A public health dental hygienist performed an intraoral screening of soft tissues to assess the need for prophylaxis, fluoride, or referral for other dental treatments by a dentist; or • In circumstances where the client will be referred to a dentist for treatment, the referring provider will not provide treatment or provide a full evaluation at the time of the assessment. <p>This procedure also includes appropriate referrals, charting, patient data and oral health status, and informing the parent or guardian of the results.</p>	See Appendix
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Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up
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Radiographs

Doing both a panoramic film and an intraoral complete series is not allowed.

Limitations:

- Periapical radiographs and bitewings on the same date of service cannot exceed HRSA's maximum allowable for a complete series.
- A maximum of four bitewing radiographs will be paid in a 12-month period.
- When billing D0270 and D0272 on the same date of service, HRSA's total reimbursement amount will not exceed the reimbursement for D0274.

D0210	Intraoral – complete series (including bitewings) A complete intraoral series consists of 14 periapicals and one series of 4 bitewings. Complete series radiographs will be allowed only once in a 3-year period.	No	See Appendix
D0220	Intraoral periapical – single, first film	No	See Appendix
D0230	Intraoral periapical – each additional film	No	See Appendix
D0270	Bitewing – single film Total of 4 bitewings allowed every 12 months.	No	See Appendix
D0272	Bitewings – 2 films Total of 4 bitewings allowed every 12 months	No	See Appendix
D0274	Bitewings – 4 films Total of 4 bitewings allowed every 12 months.	No	See Appendix
D0330	Panoramic film – Maxilla and mandilla Allowed once in a three-year period for oral surgical purposes or for DDD clients. <ul style="list-style-type: none"> • Not to be used for restoration diagnostic purposes. • A panoramic radiograph and an intraoral complete series cannot be billed within the same 3-year period. • A shorter interval between panoramic radiographs may be allowed for: <ul style="list-style-type: none"> ✓ Emergent services, with authorization from HRSA within three working days of the service; ✓ Oral surgery, with written prior authorization from HRSA; or ✓ Preoperative or postoperative surgery cases. Preoperative radiographs must be provided within 14 days prior to surgery, and postoperative radiographs must be provided within 30 days after surgery. 	No	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up
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Preventive

Prophylaxis

D1110	Prophylaxis – Adult <ul style="list-style-type: none"> Allowed once every 12 months. DDD clients may have three prophylaxis every 12 months. Not allowed when performed on the same date of service as periodontal scaling and root planing, gingivectomy or gingivoplasty. Reimbursed only if periodontal maintenance is not billed for the same client within the same 12-month period. 	No	See Appendix
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Fluoride Treatments

Document in the client's file which material (e.g., topical gel or fluoride varnish) is used.			
D1204	Topical application of fluoride [gel or varnish] <p>Allowed up to three times in a 12-month period for:</p> <ul style="list-style-type: none"> DDD clients; Adults age 19 through 64 with xerostomia - prior authorization required; or High-risk adults age 65 and older with: <ul style="list-style-type: none"> ✓ Rampant root surface decay; or ✓ Xerostomia. 	Yes	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up
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Restorative

Amalgam Restorations (including polishing)

- Amalgam restorations are covered once in a two-year period for the same surface of the same tooth per client, per provider, subject to the following:
 - ✓ Replacement of restorations is not allowed within a two-year period, unless the restoration has an additional adjoining carious surface, then all restored surfaces will be covered.
- Multiple restorations involving the proximal and occlusal surfaces of the same tooth are considered to be a single multi-surface restoration. Payment is limited to that of a single multi-surface restoration, except for teeth 2, 3, 14 and 15 (see page E.4).
- A maximum of six surfaces for a posterior tooth are allowed once per client, per provider, in a two-year period.
- Bases and polishing amalgams are included in the allowance for the major restoration.

D2140	Amalgam – 1 surface, primary or permanent Tooth and surface designations required.	No	See Appendix
D2150	Amalgam – 2 surfaces, primary or permanent Tooth and surface designations required.	No	See Appendix
D2160	Amalgam – 3 surfaces, primary or permanent Tooth and surface designations required.	No	See Appendix
D2161	Amalgam – 4 or more surfaces, primary or permanent Tooth and surface designations required.	No	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up
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Resin-Based Composite Restorations (Composite/Glass Ionomer)

<ul style="list-style-type: none"> Composite restorations are covered once in a two-year period for the same surface of the same tooth, per client, per provider subject to the following: <ul style="list-style-type: none"> ✓ Replacement of restorations is not allowed within a two-year period, unless the restoration has an additional adjoining carious surface, then all restored surfaces will be covered. Multiple restorations involving the proximal and occlusal surfaces of the same tooth are considered to be a single multi-surface restoration, except for teeth 2, 3, 14, and 15. Payment is limited to that of a single multi-surface restoration. Any interproximal restoration that does not involve the incisal angle in the anterior teeth is considered to be a two-surface restoration. Interproximal restorations involving the incisal angle are considered to be either a three or four surface restoration. All surfaces must be listed for payment. Buccal or lingual class V restorations may be billed as a separate single surface restoration. A maximum of six surfaces for an anterior or posterior tooth are allowed once per client, per provider, in a two-year period. HRSA covers flowable composites as a restoration only when used with a cavity preparation for a carious lesion that penetrates the enamel (see page E.3). HRSA does not cover flowable composites for interproximal or incisal restorations. 			
D2330	Resin-based composite – 1 surface, anterior Tooth and surface designations required.	No	See Appendix
D2391	Resin-based composite – 1 surface, posterior Tooth and surface designations required.	No	See Appendix
D2392	Resin-based composite – 2 surfaces, posterior Tooth and surface designations required.	No	See Appendix
D2393	Resin-based composite – 3 surfaces, posterior Tooth and surface designations required.	No	See Appendix
D2394	Resin-based composite, 4 or more surfaces, posterior Tooth and surface designations required.	No	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up
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Other Restorative Services

D2950	Core build-up (including any pins) HRSA pays for a core buildup on an anterior or a posterior tooth, including any pins, which is allowed once per client, per provider, in a two-year period, subject to the following: <ul style="list-style-type: none"> • HRSA does not pay for a core buildup when placed in combination with any other restoration on the same tooth on the same date of service. • Tooth designation required. 	No	See Appendix
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Endodontic

Root Canal Therapy

D3310	Anterior (excluding final restorations) <ul style="list-style-type: none"> • Includes pre-treatment diagnostic tests; • Includes follow-up treatment; and • Not covered for primary teeth. • Tooth designation required. 	No	See Appendix
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Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up
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Periodontics

Surgical Services

D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant Quadrant designation required. Allowed once every three years	No	See Appendix
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Periodontal Scaling and Root Planing

<ul style="list-style-type: none"> • Allowed for DDD clients (see page E.6). • Allowed for clients age 19 and older. • Allowed only when the client has radiographic evidence of periodontal disease. • There must be supporting documentation in the client's record, including complete periodontal charting and a definitive periodontal diagnosis. • Allowed only when the client's clinical condition meets existing periodontal guidelines. • Allowed once per quadrant in 24-month period, quadrant designation is required. • Not allowed when performed on the same date of service as oral prophylaxis, periodontal maintenance, gingivectomy or gingivoplasty. • Ultrasonic scaling, gross scaling, or gross debridement procedures may be included in the procedure, but are not substitutes for, periodontic scaling and root planing. 			
D4341	Periodontal scaling and root planing, four or more contiguous teeth or bounded teeth spaces, per quadrant	No	See Appendix
D4342	Periodontal scaling and root planing (1-3 teeth, per quadrant)	No	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up
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Periodontal Maintenance

<ul style="list-style-type: none"> • Allowed for DDD clients three times per year; • Allowed for clients age 19 and older every 6 months; • Allowed only when the client has been previously treated for periodontal disease, including surgical or nonsurgical periodontal therapy; • Allowed when supporting documentation in the client's record includes a definitive periodontal diagnosis and complete periodontal charting; • Allowed when the client's clinical condition meets existing periodontal guidelines; • Allowed when periodontal maintenance starts at least 6 months after completion of periodontal scaling and root planing or surgical treatment and paid only at 6-month intervals. • Not reimbursed when the periodontal maintenance is performed on the same date of service as oral prophylaxis or periodontal scaling and root planing, gingivectomy, or gingivoplasty. • Reimbursed only if oral prophylaxis is not billed for the same client within the same 12-month period. 			
D4910	Periodontal Maintenance [full mouth – not per quadrant]	No	See Appendix

Dentures/Partial Dentures

ALL Dentures, Partial Dentures, and Replacement of Dentures or Partial Dentures REQUIRE PRIOR AUTHORIZATION
See page E.13 for details on requesting prior authorization.

Dentures, partial dentures require labeling in accordance with RCW 18.32.695.

Dentures

[Refer to WAC 388-535-1290(2) and (3)]

HRSA covers the following for eligible adults:

- Only one complete maxillary and one complete mandibular denture per client in a ten-year period, when constructed after the client had been without teeth for a period of time; or
- Only one immediate maxillary denture and one immediate mandibular denture allowed per client, per lifetime, and only when constructed prior to the removal of the client's teeth.

The dentures must be of an acceptable structure and quality to meet the standard of care. HRSA does not cover transitional dentures.

Partial Dentures

[Refer to WAC 388-535-1290(2)(c)]

HRSA covers the following for eligible adults:

- Only one maxillary partial denture (resin) and one mandibular partial denture (resin) to replace one, two, or three missing anterior teeth per arch, allowed per client in a ten-year period; or
- Only one maxillary partial denture (cast metal framework) and one mandibular partial denture (cast metal framework) allowed per client in a ten-year period to replace:
 - a. Any combination of at least six anterior and posterior missing teeth per arch excluding wisdom teeth; or
 - b. At least four anterior missing teeth per arch.

Prior Authorization for Complete Dentures

[Refer to WAC 388-535-1290(1)]

- HRSA requires prior authorization for complete dentures.
- Requests for prior authorization must include:
 - ✓ Whether the client was successfully able to wear dentures in the past; and
 - ✓ If not, reason why not and why client would be able to wear dentures now.

Prior Authorization for Immediate Dentures and Partial Dentures

[Refer to WAC 388-535-1290(1)]

Clinical justification is required from a dentist for immediate dentures and partial dentures.

- HRSA requires prior authorization for immediate dentures and partial dentures, described in this section.
- For immediate dentures, the client's dentist must initiate request for authorization from HRSA and provide periodontal charting (when appropriate), periodontal diagnosis, and radiographs.
- For partial dentures, the client's dentist must initiate request for authorization from HRSA and provide:
 - ✓ Charting of missing teeth;
 - ✓ Periodontal charting;
 - ✓ Periodontal diagnosis;
 - ✓ Radiographs;
 - ✓ Documentation of whether the client has current partials; and
 - ✓ Documentation of why the partial denture cannot be relined or repaired.
- If a different dentist/denturist is providing the immediate or partial dentures, that dentist/denturist must contact HRSA for the prior authorization number.

Relines [WAC 388-535-1290(9)(10)]

- **HRSA covers complete denture and partial denture relines only once in a five-year period.**
- **HRSA does not require prior authorization for repairs.**
- **HRSA does not pay separately for relines that are done within six months of the seat date. For this time period, these procedures are included in the reimbursement for the dentures and partial dentures.**

Repairs [WAC 388-535-1290(5)]

- **HRSA covers complete denture and partial denture repairs, when medically necessary.**
- **HRSA does not require prior authorization for repairs.**
- **HRSA does not pay separately for repairs that are done within six months of the seat date. For this time period, these procedures are included in the reimbursement for the dentures and partial dentures.**

Replacement of Complete Dentures or Partial Dentures

[Refer to WAC 388-535-1290(2)(d) and (6)]

HRSA covers the following for eligible adults:

- Only one replacement of a complete maxillary denture and one replacement of a complete mandibular denture allowed per client in a ten-year period; or
- Only one replacement of a maxillary partial denture (cast metal framework) and a mandibular partial denture (cast metal framework) allowed per client in a ten-year period.

Replacement of complete dentures and partial dentures must:

- Replace a complete maxillary denture, a complete mandibular denture, a maxillary partial denture (cast metal framework) or a mandibular partial denture (cast metal framework);
- Replace dentures or partial dentures that are no longer serviceable and are unable to be relined;
- Replace dentures or partial dentures that are damaged beyond repair; and
- Replace dentures or partial dentures that a client has been able to wear successfully.

Billing [WAC 388-535-1290(7) and (8)]

For billing purposes, the provider must:

- a. Use the delivery date as the service date for the dentures and partial dentures; or
- b. Use the impression date as the service date for dentures and partial dentures only when:
 - i. Related dental services, including laboratory services, were provided during a client's eligible period;
 - ii. The client is not eligible at the time of delivery; and
 - iii. The client does not return to obtain the dentures or partial dentures.

The provider must document in the client's record:

- a. Written laboratory prescriptions;
- b. Receipts for laboratory fees;
- c. Receipts for laboratory records;
- d. Charting of missing teeth for partial dentures; and
- e. Documentation that justifies the placement or replacement of dentures or partial dentures.

Laboratory and Professional Fees for Dentures/Partial Dentures [Refer to WAC 388-535-1290(9)]

HRSA does not pay separately for laboratory and professional fees for dentures and partial dentures. However, HRSA may partially reimburse for these fees when the provider obtains prior authorization and the client:

- Dies;
- Moves from the state;
- Cannot be located; or
- Does not participate in completing the dentures.

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up
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Complete Dentures (including 6 months post-delivery care)

- The HRSA dental program covers one maxillary and one mandibular denture in a 10-year period.
- No additional reimbursement is allowed for denture seat/delivery.
- D5110 through D5140 **require prior authorization from HRSA.**

D5110	Complete denture – maxillary (upper) Requires Prior Authorization	Yes	See Appendix
D5120	Complete lower – mandibular (lower) Requires Prior Authorization	Yes	See Appendix
D5130	Immediate denture – maxillary (upper) Appropriate radiographs must be submitted to HRSA. Requires Prior Authorization	Yes	See Appendix
D5140	Immediate denture – mandibular (lower) Appropriate radiographs must be submitted to HRSA. Requires Prior Authorization	Yes	See Appendix

Partial Dentures (including 6 months post-delivery care)

- D5211 and D5212 are covered for 1-3 missing anterior teeth, excluding wisdom teeth.
- D5213 and D5214 are covered only when replacing any combination of 6 anterior and posterior missing teeth per arch or 4 or more anterior missing teeth per arch.
- D5211 through D5214 **require prior authorization from HRSA.**

D5211	Maxillary partial denture – resin base (includes any conventional clasps, rests and teeth) Requires Prior Authorization	Yes	See Appendix
D5212	Mandibular partial denture – resin base (includes any conventional clasps, rests and teeth) Requires Prior Authorization	Yes	See Appendix
D5213	Maxillary partial denture – cast metal framework with resin denture bases (includes any conventional clasps, rests and teeth) Requires Prior Authorization	Yes	See Appendix
D5214	Mandibular partial denture – cast metal framework with resin denture bases (includes any conventional clasps, rests and teeth) Requires Prior Authorization	Yes	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up
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Lab and Professional Fees for Complete/Partial Dentures

D5899	<p>Unspecified removable prosthodontic procedure</p> <p>Laboratory and professional fees may be paid for complete dentures or partial dentures if the patient:</p> <ul style="list-style-type: none"> • Dies; • Moves from the state; • Cannot be located; or • Does not participate in completing the dentures. <p>Requires prior authorization from HRSA.</p> <p>When requesting prior authorization, attach an invoice listing laboratory prescriptions and fees.</p>	Yes	See Appendix
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Repairs to Complete Dentures

D5510	<p>Repair broken complete denture base Arch designation required.</p>	No	See Appendix
D5520	<p>Replace missing or broken teeth – complete denture Use for initial tooth. Tooth designation required.</p>	No	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up
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Repairs to Partial Dentures

D5610	Repair resin denture base Arch designation required.	No	See Appendix
D5620	Repair cast framework Arch designation required.	No	See Appendix
D5630	Repair or replace broken clasp Arch designation required.	No	See Appendix
D5640	Replace broken teeth – per tooth Use for initial tooth. Tooth designation required.	No	See Appendix
D5650	Add tooth to existing partial denture Tooth designation required.	No	See Appendix
D5660	Add clasp to existing partial denture Tooth designation required.	No	See Appendix

Denture Relining

<ul style="list-style-type: none"> • Relines are included in allowance for dentures if service is provided within first six months of placement of dentures. • Reline of partial or full dentures is not allowed more than once in a 5-year period. 			
D5750	Reline complete maxillary denture (laboratory)	No	See Appendix
D5751	Reline complete mandibular denture (laboratory)	No	See Appendix
D5760	Reline maxillary partial denture (laboratory)	No	See Appendix
D5761	Reline mandibular partial denture (laboratory)	No	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up
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Oral Surgery – Dentists

HRSA covers dental services that are medically necessary and provided in a non-office setting under the direction of a physician or dentist for:

- a) The care or treatment of teeth, jaws, or structures directly supporting the teeth, if the procedure requires hospitalization;
- b) Short stays or ambulatory surgery centers when the procedure cannot be done in an office setting (See “What dental-related services are not covered,” page E.10); and
- c) A hospital call, including emergency care, allowed one per day, per client, per provider.

Simple Extraction (includes local anesthesia, suturing, if needed, and routine postoperative care)

D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No	See Appendix
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth Anterior teeth (7-10 and 23-26) require prior authorization and must be justified with radiographs. Tooth designation required.	See desc.	See Appendix
D7220	Removal of impacted tooth – soft tissue Tooth designation required.	No	See Appendix
D7230	Removal of impacted tooth – partially bony Tooth designation required.	No	See Appendix
D7240	Removal of impacted tooth – completely bony Allowed only when pathology is present. Tooth designation required.	No	See Appendix
D7241	Removal of impacted tooth - completely bony with unusual surgical complications	No	See Appendix
D7250	Surgical removal of residual tooth roots (cutting procedure)	No	See Appendix
HRSA does not cover extraction of asymptomatic teeth. [WAC 388-535-1100(2)]			

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up
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Adjunctive General Services

Unclassified Treatment

D9110	Palliative (emergency) treatment of dental pain – minor procedure <ul style="list-style-type: none"> Emergency palliative treatment is: <ul style="list-style-type: none"> ✓ Covered only when no other definitive treatment is performed on the same day; and ✓ Covered once per client, per day. A description of the treatment performed must be documented in the client's record. Not allowed when performed on the same date as root canal therapy. 	No	See Appendix
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Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up
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Anesthesia

HRSA covers the following anesthesia services as follows:

General Anesthesia

- For treatment of adults who are eligible under the Division of Developmental Disabilities;
- For medically necessary oral surgery procedure codes listed in HRSA's Dental Billing Instructions, dated October 2003, pages F.5-F.15;

Conscious Sedation

- For treatment of adults who are eligible under the Division of Developmental Disabilities;
- For medically necessary oral surgery procedure codes listed in HRSA's *Dental Billing Instructions*, dated October 2003, pages F.5-F.15 and page E.35;
- HRSA covers the above anesthesia services when the anesthesia is administered by:
 - ✓ An oral surgeon;
 - ✓ An anesthesiologist;
 - ✓ A dental anesthesiologist;
 - ✓ A Certified Registered Nurse Anesthetist (CRNA), if the performing dentist has a current conscious sedation permit or a current general anesthesia permit from the Department of Health (DOH); or
 - ✓ A dentist who has a current conscious sedation permit or a current general anesthesia permit from DOH.
- When the provider meets the prevailing standard of care and at least the requirements in WAC 246-817-760, Conscious sedations with parenteral or multiple oral agents, and WAC 246-817-770, General anesthesia.
- When billing for general anesthesia, show the actual beginning and ending times on the claim form. State the total number of minutes on the claim. Anesthesia time begins when the anesthesiologist or CRNA starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent) and ends when the anesthesiologist or CRNA is no longer in constant attendance (i.e., when the patient can be safely placed under post-operative supervision).
- The name of the provider who administered the anesthesia must be in the *Remarks* field (field 35) of the claim form, if that provider is different from the billing provider.
- HRSA calculates payment according to the formula below for general anesthesia (to include deep sedation) administered by a dentist:

\$101.15 + [TIME UNITS X \$20.23] = MAXIMUM ALLOWABLE FEE

Note: Every 15 minute increment or fraction equals 1 time unit.

Dental Program

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up
<ul style="list-style-type: none"> Bill for pharmaceuticals using the appropriate code(s) below. If you are billing electronically, attach an itemized list of pharmaceuticals to the claim form. Send this information to HRSA as backup documentation for electronically billed claims for any charges exceeding \$45.00 (see <i>Important Contacts</i>). Documentation of medical necessity must be kept in the client's file. 			
D9220	<p>Deep sedation/general anesthesia</p> <p>HRSA's reimbursement for D9220 includes the total time – not just the first 30 minutes as specified in the CDT book. See previous page for further information.</p> <p>(A General Anesthesia permit is required to be on file with HRSA from the provider/performing provider.)</p>	No	See Appendix
D9230	<p>Analgesia, anxiolysis, inhalation of nitrous oxide</p> <p>HRSA does not cover analgesia or anxiolysis under the Dental Program. Use this code when billing for inhalation of nitrous oxide.</p>	No	See Appendix
D9241	<p>Intravenous conscious sedation/analgesia</p> <p>Conscious sedation with parenteral agents.</p> <p>(A Conscious Sedation permit is required to be on file with HRSA from the provider/performing provider.)</p>	No	See Appendix
D9248	<p>Non-intravenous conscious sedation</p> <p>Conscious sedation with multiple oral agents.</p> <p>(A Conscious Sedation permit is required to be on file with HRSA from the provider/performing provider.)</p>	No	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up
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Professional Visits

- Nursing facilities must provide dental-related necessary services per WAC 388-97-012.
- No additional payment will be made for multiple calls for patients in nursing facility settings.
- Procedures including evaluations or assessments must be billed with the appropriate procedure codes.
- A referral for dental care must be documented in the client's record. This referral may be initiated by the client, client's attending physician, facility nursing supervisor, or client's legal guardian when a dental problem is identified.
- The client or guardian has freedom of choice of dentist in the community. The on-staff dental provider may be called when the patient has no preference and concurs with the request.
- Medicaid-eligible clients in nursing facilities may not be billed for services that exceed those covered under this program. Services outside this program should be arranged by the nursing facility and may be covered under their rate structure.
- Mass screening for dental services of clients residing in a facility is not permitted.

D9410	House/extended care facility call Allowed once per day, per facility, per provider, limited to three calls.	No	See Appendix
D9420	Hospital calls (includes emergency care) Allowed once per day, per client, per provider. Not covered for routine preoperative and postoperative visits.	No	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up
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Drugs

D9630	Other drugs and/or medicaments Use this code when billing for pharmaceuticals. Payable only when billed with either D9220, D9241, or D9248. HRSA limits this procedure code to parenteral and multiple oral agents for conscious sedation and general anesthesia agents only.	No	See Appendix
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Miscellaneous Services

D9920	Behavior management <ul style="list-style-type: none"> Requires the assistance of one additional dental professional staff A description of behavior management procedures performed must be documented in the client's record. 	No	See Appendix
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